

## MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-040714

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 10013

STATE FILE NUMBER

FILED OCT 29 1962

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		c. CITY OR TOWN <u>St. Louis</u>	
Length of stay in 1b <u>56 yrs</u>		Inside Limits <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Jewish Hosp.</u>		d. STREET ADDRESS (If outside, give location) <u>339 Taylor</u>	
Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		Reside on Farm <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
First <u>ALBERT</u> Middle <u>SCHNURR</u> Last <u>SCHNURR</u>		Month <u>Oct</u> Day <u>18</u> Year <u>1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>unk.</u>
9. AGE (last birthday) <u>ab. 56</u>		IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retail wear</u>	
11. BIRTHPLACE (City and state or country) <u>St. Louis, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Louis Schnurr</u>		13b. MOTHER'S MAIDEN NAME <u>Pearl Rothman</u>	
14. NAME OF HUSBAND OR WIFE <u>--</u>		Address	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>[redacted]</u>	
17. INFORMANT <u>Anna Kaplan 6935 Roberts</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line if PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>420.0</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Right Mid Shigh Amputation</u>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour <u>9:30</u> a.m. p.m. Month, Day, Year <u>8/25/61</u>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION <u>4268 Delor</u> COUNTY STATE	
21. I attended the deceased from <u>8/25/61</u> to <u>10/18/62</u> and last saw him alive on <u>10/18/62</u>		Death occurred at <u>9:30/A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Degree or title) <u>Cecilia Hendrix MD</u>		22b. ADDRESS <u>4268 Delor</u>	
22c. DATE SIGNED <u>10/19/62</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Rem.</u>	23b. DATE <u>10/19/62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Chesed Shel Meth</u>	
23d. LOCATION (City, town, or county) <u>University City, Mo.</u>		(State)	
24. FUNERAL DIRECTOR <u>Berger Memorial 4715 McPherson</u>		25. DATE RECD. BY LOCAL REG. <u>OCT 19 1962</u>	
26. REGISTRAR'S SIGNATURE <u>Joan Smith MD</u>			

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK  
OR  
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

VS 300  
Rev. 4/59

1

2

3

4

5

6

7

8

9

10

11

12

13

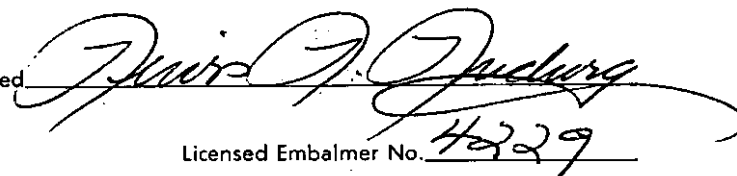
64

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed

  
Licensed Embalmer No. 4229

P. O. Address \_\_\_\_\_

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.